**South Carolina Workers' Compensation Commission**
1612 Marion St. • P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5723

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: ___-___-_____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - Work Phone: ( ) - Insurance Carrier: _____

Preparer's Name: _____ Preparer's Phone #: ( ) -

Date of injury: _____

1. Temporary Compensation Paid:

| Number of Weeks | From | To | Amount |
|---|---|---|---|
| _____ | _____ | _____ | $ _____ |
| _____ | _____ | _____ | $ _____ |
| _____ | _____ | _____ | $ _____ |
| _____ | _____ | _____ | $ _____ |
| _____ | _____ | _____ | $ _____ |

2. The claimant returned to work on _____ (month day year)
☐ With restrictions but at a salary not less than before the injury.
☐ Without restrictions.

3. The claimant agrees he or she was able to return to work on _____. (month day year)

I agree that I was disabled for the period(s) indicated and I was paid compensation as shown above. **I UNDERSTAND THAT MY WEEKLY TEMPORARY COMPENSATION CHECKS WILL STOP; HOWEVER, I GIVE UP NO RIGHTS TO COMPENSATION FOR FUTURE DISABILITY, FOR PERMANENT DISABILITY, DISFIGUREMENT OR MEDICAL CARE.** The effect of this form has been fully explained to me, and I have received a copy of it. I understand that I should not sign this form until 15 days after I have returned to work or agree I was able to return to work.

_____ _____
Claimant's Signature Employer's Representative Signature

_____ _____
(Check one) ☐ Witness ☐ Claimant's Attorney Date Agreement Signed

File this form with the Claims Department no later than 31 days from the date the claimant returned to work to terminate temporary compensation after the first 150 days after employer's notice of the injury according to R.67-505. Within the 150 period, obtain Form 17 to document that claimant agrees he or she is able to return to work.